JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Eating Disorder Clinical Pathway

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Updated: August 2025
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This pathway is intended as a guide for physicians, physician assistants, nurse practitioners and other healthcare providers. It should be adapted to the care of specific patient based on the patient's individualized circumstances and the practitioner's professional judgment.

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Eating Disorder Clinical Pathway

Rationale:

This clinical pathway was developed by a consensus group of physicians and a multidisciplinary team at Johns Hopkins All Children's Hospital (JHACH) to standardize the management of children hospitalized for suspected or confirmed eating disorders (EDs). It addresses the following clinical questions or problems:

1. The care plan goals for medical stabilization and nutritional resuscitation of a patient with suspected or confirmed ED
2. Admission criteria for a patient with suspected ED
3. Feeding plan for a patient with a suspected ED
4. Treatment team communication
5. Discharge criteria

Background:

EDs are complex illnesses that are becoming increasingly frequent among preadolescents and adolescents. These disorders are associated with serious biological, psychological, emotional, and sociological morbidity, as well as significant mortality, resulting from disturbance in eating behaviors, distortion of perceived body image, and obsessional thoughts and rituals. Early recognition and treatment are crucial to recovery.

Diagnosis:

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) provides the full diagnostic criteria for each of the following EDs commonly seen in children and adolescents:

Anorexia nervosa is characterized by:

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health
- Intense fear of gaining weight or becoming fat, even though underweight
- Disturbance in the way one experiences one's body weight or shape; undue influence of body weight or shape on self-evaluation; or denial of the seriousness of current low body weight
- Individuals with anorexia nervosa, restricting type, severely restrict how much food they eat and the types of food they consume; this may also be paired with excessive exercise
- Individuals with anorexia nervosa, binge/purging type, also severely restrict how much food they eat and the types of food they consume, but have also purged their food through self-induced vomiting or misused laxatives/diuretics/enemas within the last three months; they may binge as well

Bulimia nervosa is characterized by:

- Recurrent episodes of binge eating (consumption of excessive amounts of food within a short period); lack of control overeating during the episode
- Recurrent inappropriate compensatory behaviors to prevent weight gain
- Self-evaluation is unduly influenced by body shape and weight

Avoidant/restrictive food intake disorder (ARFID) is characterized by:

- Eating disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs and associated with significant weight loss, significant nutritional deficiency, dependence on enteral feeding or supplementation, and/or marked interference with psychosocial functioning
    - Examples of eating disturbances include, but are not limited to, apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating
- No evidence of disturbance in the way one experiences one's body shape or weight

Other specified or unspecified feeding or EDs are characterized by:

- ED that causes significant distress or impairment but does not meet full criteria for another disorder

Note: While several other disorders are classified as feeding and eating disorders in the DSM-5, including pica, rumination disorder, and binge-eating disorder, the disorders mentioned above are the most likely to require medical management utilizing the *Eating Disorder Clinical Pathway* if the patient meets admission criteria.

Clinical Management:

Care plan goals:

- Medically stabilize patients meeting criteria for inpatient admission due to medical complications of anorexia nervosa or other EDs
- Take a unified, multidisciplinary approach to provide support for immediate physical and psychiatric needs as they are identified
- Facilitate communication among team members, the patient, and caregiver(s)
- Monitor patient for complications related to malnutrition and refeeding, including, but not limited to, electrolyte derangement and physiologic instability (e.g., orthostasis, arrhythmia, bradycardia, hypotension, hypothermia)
- Empower and support the patient and caregiver(s) in accessing available resources for ongoing care after hospital discharge

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Eating Disorder Emergency Center (EC) Clinical Pathway

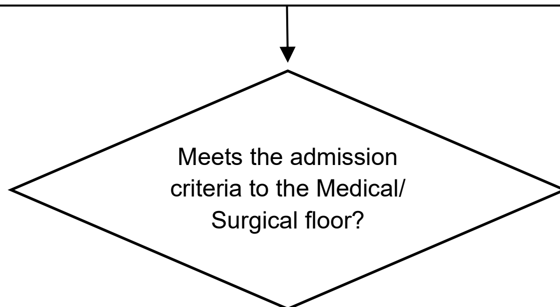
Medical Stabilization for Patients with Suspected or Confirmed Eating Disorders

EC Assessment:

- Obtain vital signs, including orthostatic HR and BP, and oral temperature
  - EC orthostatic vital signs: Measure HR and BP after 5 minutes supine, then after 1 minute standing and 3 minutes standing
- Obtain height and weight (weight should be obtained while the patient is rear facing, in a gown and undergarments only). *Do not discuss weight with the patient!*
- Obtain labs: CMP, urine pregnancy, Mg, Phos
- ASQ Suicide Screening to be completed by nursing; if screen positive, SW consult
- ASQ to be completed by nursing; if screen positive, SW consult for suicide risk assessment

Admission Criteria: (can include any of the following)

- Weight < 75th IBW
  - EC providers may use the calculation method in Appendix A as a screening tool to determine if the patient meets admission criteria
- Continued weight loss despite intensive outpatient therapy
- Acute weight decline and refusal of food
- Hypothermia (< 35.6 °C (96 °F))
- Hypotension (SBP < 90 mmHg)
- Bradycardia (resting HR < 50 bpm while awake and < 45 bpm while asleep)
- Orthostatic changes in BP (decrease in SBP of at least 20 mmHg)
- Orthostatic changes in HR (increase in HR by at least 20 bpm)
- Electrolyte abnormalities
- Arrhythmia



NO

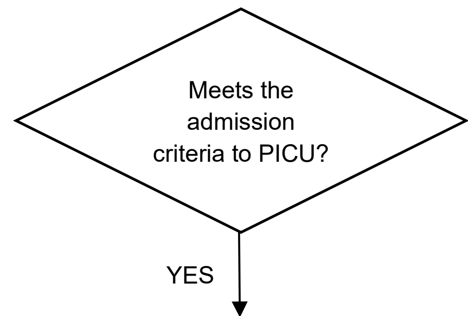
- Refer to SW for assistance with providing appropriate outpatient and community resources for discharge

YES

- Contact Hospitalist
- Place an NG tube
- Implement ED Pathway
- Counsel caregiver(s) that JHACH provides medical stabilization and initiation of nutritional resuscitation, and is not a licensed ED treatment center

Consider admission to the PICU for any of the following:

- HR < 30 bpm, regardless of symptoms
- HR < 40 bpm with syncope
- Cardiac arrhythmia
- QTc greater than 500 ms
- Electrolyte derangements requiring IV replacement that cannot be carried out on the floor or requiring telemetry



YES

- Contact Intensivist
- Proceed with placement of NG tube if no clinical contraindications
- Implement the ED Pathway
- Counsel caregiver(s) that JHACH provides medical stabilization and initiation of nutritional resuscitation, and is not a licensed ED treatment center

Abbreviations: ASQ, Ask Suicide-Screening Questions; BP, blood pressure; bpm, beats per minute; C, Celsius; CMP, comprehensive metabolic panel; F, Fahrenheit; HR, heart rate, IBW, ideal body weight; IV, intravenous; Mg, magnesium; ms, milliseconds; NG, nasogastric; Phos, phosphorus; PICU, Pediatric Intensive Care Unit; QTc, corrected QT interval; SBP, systolic blood pressure; SW, Social Work

EC Management:

- Presenting symptoms may include restriction of oral intake, purging behaviors, acute weight loss, fear of eating or food refusal, calorie counting, obsession with weight or body image, bradycardia, syncope, amenorrhea, lanugo, excessive exercise, intense fear of weight gain, dehydration, or other eating-related parental concerns
- When patients present to the EC with a suspected or confirmed ED and may require medical stabilization, obtain history, anthropometrics, vital signs, screening labs, and an electrocardiogram (EKG) to determine disposition and need for inpatient admission
- Orthostatic measurements: HR and BP after 5 minutes of supine rest, then after 1 minute of standing and after 3 minutes of standing (per EC protocol for obtaining orthostatic vital signs)
- If the patient meets any criteria or there is continued suspicion of an ED diagnosis, as mentioned above, but the patient remains medically stable for discharge, ensure SW has met with the caregiver(s) to provide mental health resources, which may include ED specialists and treatment centers
  - Additionally, recommend routine primary care provider (PCP) visits and referral to the JHACH Adolescent Medicine Eating Disorder Clinic
- If admission is required, an NG tube is to be placed before transfer to the inpatient unit, when possible
- The admitting team is responsible for introducing the goals and highlighting the care plan with the caregiver(s) upon admission
  - The admitting nurse (RN) is responsible for distributing handouts to the patient, caregiver(s), and Constant Patient Observer (CPO) (see "Inpatient Management")
- Consult EC SW to complete a suicide risk assessment when ASQ is positive per policy; otherwise, psychosocial assessment is to be completed in EC or upon admission

<u>*Admission criteria*</u>: (*can include any one of the following criteria)*

- Weight < 75th percentile of IBW
  - EC providers may use the calculation method in Appendix A as a screening tool to determine if the patient meets inpatient criteria
  - Registered Dietitians (RD) and Hospitalists should use the following formula during their assessment, as supported by medical literature:
    - IBW = 50th percentile body mass index (BMI) for exact age and height at presentation on the Centers for Disease Control (CDC) BMI-for-age percentiles chart (See Appendix A)
- Continued weight loss despite intensive outpatient therapy
- Acute weight decline and refusal of food
- Hypothermia (< 35.6 ˚C (96 ˚F))
- Hypotension (SBP < 90 mmHg)
- Bradycardia (resting HR < 50 bpm while awake and < 45 bpm while asleep)
- Orthostatic changes in BP (decrease in SBP of at least 20 mmHg)
- Orthostatic changes in HR (increase in HR by at least 20 bpm)
- Electrolyte abnormalities
- Arrhythmia

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Eating Disorder Inpatient Clinical Pathway

Medical Stabilization for Patients with Suspected or Confirmed Eating Disorders

Medical/Surgical/PICU Assessment:

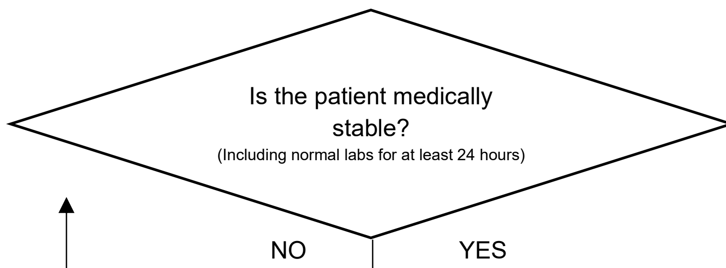
- Obtain vital signs, including orthostatic HR and BP, and oral temperature
    - Inpatient orthostatic vital signs: HR and BP after 5 minutes supine then after 3 minutes standing
- Obtain height and weight (weight should be obtained while the patient is rear facing, in gown and undergarments only). *Do not discuss weight with the patient!*
- Obtain labs: CMP, Mg, Phos, thyroid function studies, zinc, vitamin D (25-OH vitamin D), amylase, serum ferritin, CRP, and lipase

Upon Admission:

- NG tube will remain in place through the duration of admission – begin on 24/7 continuous feeds (Phase 1)
- Start supplements: multivitamin with iron, calcium carbonate, vitamin D3, zinc, thiamine/vitamin B1
- Place necessary consults: Nutrition, SW, Psychology, Child Life, and CM
- Order CPO for 24/7 monitoring
- Admitting RN to provide handouts to the caregiver(s), patient, and CPO
- If PICU, transfer to the Medical/Surgical floor when critical symptoms resolve

During Admission:

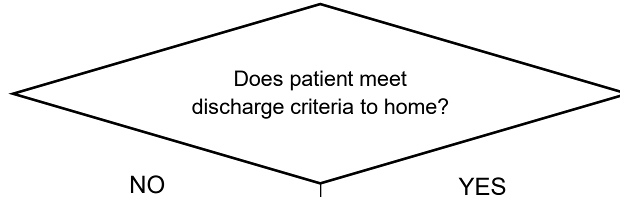
- Monitor for refeeding syndrome: BMP, Mg, Phos daily for at least the first 3 days of admission
- Post-void weight will be obtained daily by 0700
- Once vital signs are stable (HR > 50 bpm while awake, HR > 45 bpm while asleep, BP normal for age and height) for 24 hours, vital signs can be spaced to QShift
- Patient will move to Phases 2 and 3 of the feeding plan at the discretion of the RD
- SW to plan care conference within 1 – 2 weekdays of admission, with additional conferences as needed
- SW to coordinate referrals and assessments with the appropriate level of care for ongoing ED treatment
- CM to assist with verifying insurance and mental health benefits
- CPOs to monitor patient behavior and compliance with ED Pathway standards
- Provide referral to the JHACH Adolescent Medicine ED Clinic



NO

- Continued monitoring of refeeding syndrome and vital signs
- Consider additional medications/supplements
- Continued followed up by all subspecialties originally consulted

YES



NO

Discharge to Inpatient/Residential Treatment:

- Provider: Update clinical notes to document medical stability and need for use of NG and CPO
- SW: Coordinate with treatment programs and, once accepted, notify caregiver(s) and provide contact information
- CM: Get safe transport and treatment authorized
- Nursing: Complete interfacility transfer form
- NG remains in place for transport *if* NG is still the primary form of nutritional intake

YES

Discharge to PHP/IOP/Outpatient Treatment:

- HR > 50 bpm while awake, HR > 45 bpm while asleep, no EKG changes, no symptomatic orthostasis, normal temperature (> 36 °C (96.8 ˚F)), normal BP
- Patient is consuming the minimum amount of nutrition necessary as determined by the RD and medical team
- Plan of care in place, including appointments made and confirmed with appropriate providers
- If the NG tube is no longer in use, remove it at the time of discharge

Abbreviations: BMP, basic metabolic panel; CM, Case Management; CRP, c-reactive protein; IOP, intensive outpatient program; PHP, partial hospitalization programs

Inpatient Management:

Patient care:

- All patients will have an NG tube placed in the EC or immediately upon admission
  - The NG tube will stay in place until the day of discharge
- Admitting RN will be responsible for printing and distributing the following four handouts once the ED Pathway is initiated:
  - For CPO: Appendix E - "Eating Disorder Constant Patient Observer Checklist" (2 pages)
  - For patient: "Patient Handout" (Appendix F for English OR Appendix G for Spanish)
  - For caregiver(s): "Caregiver Handout" and "Tips for Caregivers" (Appendix F for English OR Appendix G for Spanish)
    - Please also provide a JHACH Adolescent Medicine Eating Disorder Clinic handout
- Orthostatic vital signs will be obtained on admission and every morning until normalized
  - Orthostatic measurements per floor protocol for patients with eating disorders: HR and BP after 5 minutes of supine rest, then after 3 minutes of standing
  - An increase in HR of more than 20 bpm is considered orthostatic tachycardia, and a SBP decrease of more than 20 mmHg is considered orthostatic hypotension
  - This protocol and criteria are based on reference 13 [Hornberger 2021] and different from the EC orthostatic vital signs, which will continue to be done with the extra set of vital signs at one minute standing based on their protocol for all patients
- Initially, vital signs will be monitored per unit protocol
  - Only oral temperatures will be utilized
- Once vital signs are stable (HR > 50 bpm while awake, HR > 45 bpm while asleep, BP normal for age and height) for 24 hours, if the patient is not otherwise eligible for discharge, vital signs can be monitored every shift
- Post-void weight will be obtained daily by 0700, and the patient will be rear-facing and in a hospital gown and undergarments only while being weighed
  - Weight will never be discussed with the patient
- CPO will be ordered for 24 hours/day
- Patient is not permitted to exercise throughout admission
  - This includes but is not limited to pacing, repetitive or frequent movements around the room, repetitive contracting and relaxing of muscles (i.e., sit-ups, crunches, social media fads, leg lifts, calf raises), and standing activity center activities (i.e., pool, walkway floor activity, stair use)
  - The patient may be in a chair, on the couch, or in bed
- The patient can leave the room escorted by the CPO
  - Patient must be in a wheelchair for the duration of the excursion
  - Please notify the RN or Charge RN before leaving the unit
  - Excursions may not interfere with meals or snack times
    - Patient is not permitted to visit the café or cafeteria

- The patient cannot use the bathroom for 60 minutes following the completion of meals
- Patient is permitted one shower per day
- Thermostat will be set in the middle (12 o'clock position) by the CPO or RN and is not to be changed by the patient or caregiver(s)
- The patient will not be allowed to chew gum

Consults and referrals:

- Nutrition, SW, Psychology, Child Life, and CM should be consulted upon admission
- A referral to the JHACH Adolescent Medicine Eating Disorder Clinic
- should be ordered upon admission due to wait times to get into the clinic
    - Order Outpatient Referral to Adolescent Medicine and type "Eating Disorder Clinic" in the comments
    - The goal is for the patient to be followed in the JHACH Adolescent Medicine Eating Disorder Clinic during AND after any intensive therapy program they enter upon discharge
- A Psychiatry consult should be considered if assistance with psychotropic medication management is needed
- Academic Services consultation may be considered depending on the length of stay and the caregiver's interest

Diet:

Upon admission:

- NG tube is placed upon admission and will remain in place until discharge
    - If the NG tube becomes dislodged for any reason, it will be replaced promptly
    - Patient to start on continuous NG feeds per the feeding plan outlined below
    - The RD will determine the appropriate time to start the meal plan once they have assessed the patient
- Excluding formula and nutritional supplements, an oral fluid restriction of 1,000 mL/day will be in place during the entire admission
    - Oral fluid restriction does not include fluids sent by the RD on meal plan trays
    - No caffeinated beverages are permitted
    - When daily polyethylene glycol (MiraLAX®) is prescribed, patients are permitted 8 ounces of fluid to mix it in that does not count toward their oral fluid restriction
- Patient to have a regular diet for age ordered upon admission
    - The patient can consume food in addition to enteral feeds
- Nursing to cover the enteral pump and formula with a pillowcase to avoid the patient fixating on numbers/attempting to calorie count
    - Formula in cartons or cans will not be brought into the room by nursing to avoid fixation on numbers/attempts to calorie count

When the meal plan is initiated:

- Food from home is allowed, but does not count towards the meal plan established by the RD

  - The food is counted in addition to the meal plan
- Accommodations for medically approved food allergies, religious exemptions, and vegetarian preferences will be made at the RD's or medical team's discretion
- Each meal or snack must be completed within the allotted 30-minute timeframe
- Meals will occur in the patient's room, in a stand-alone chair, supervised by medical staff
  - Caregiver(s) can be present, but will be asked to leave if not able to display supportive behaviors during meals
  - TV use is allowed during meals for distraction, unless the patient is watching triggering content
- Food labels (on meal trays or formula) should not go into the patient's room to ensure the patient is not fixating on numbers/calories
- If the patient is found throwing away food or manipulating enteral feeds, the RD will adjust the nutrition plan accordingly to ensure nutrition goals are met
- Patient may be allowed to wear personal clothing unless concerning behaviors occur, at which time the medical team may modify the arrangements and transition the patient into a hospital gown
- The patient will not be allowed to chew gum

Feeding plan: (The feeding plan will be implemented in the following order, but may be modified at the discretion of the RD)

- Phase 1:
  - Continuous NG feeds 24 hours/day will be started on admission based on age:
    - Patients 8 – 13 years old: PediaSure® 1.5 at 42 mL/hour for 24 hours
    - Patients 14 years and older: Vital® 1.5 at 55 mL/hour for 24 hours
  - The RD will see the patient within 24 hours of admission and calculate the patient's goal calorie intake/enteral rate
  - Continuous NG feeds will be advanced by 200 kilocalories (kcal) (or 6 mL/hour) every day until the goal calorie intake is achieved or per the RD's recommendations
  - The patient will be on a regular diet for age with a 1000 mL fluid restriction and can order food by mouth as desired

- Phase 2:
  - Once maximum calories are achieved via NG supplementation (or earlier at the discretion of the RD), the RD will initiate an oral feeding plan with three meals and 1 – 3 snacks per day
    - The menu will be pre-selected by the RD and sent to the kitchen the day prior
    - Feeds increased at the following rate, pending acceptance of the food orally (PO)
      - 1st day: 50% kcals from PO meal plan + 50% kcal via NG at night
      - 2nd day: 75% kcals from PO meal plan + 25% kcal via NG at night

        - 3rd day: 100% kcals from PO meal plan + 0% kcal via NG at night
    - If the patient refuses any portion of a meal or snack, or does not complete 100% within 30 minutes, a full kcal equivalent of formula will be offered PO
        - It will be given via NG if the PO is refused

- Phase 3:
    - 100% of nutrition needs are met via PO meal plan, with no scheduled NG feeds, unless the patient refuses any portion of a meal or snack
    - The NG tube will stay in place until the day of discharge

Laboratory evaluation:

- On admission: CMP, Mg, Phos, thyroid function studies, zinc, vitamin D (25-OH vitamin D), amylase, serum ferritin, CRP, and lipase
    - If the patient has had zinc, ferritin, vitamin D, and thyroid function labs within the last 3 months, repeat labs may not be necessary
- Consider serum B12 and methylmalonic acid (MMA) if the patient is on a vegan diet
- Consider urine pregnancy screening on admission, if not already performed
- BMP, Mg, and Phos levels will be monitored upon admission to assess for refeeding syndrome
- Recommend checking BMP, Mg, Phos daily for the first 3 days of admission
    - If labs remain stable after the first 3 days, recheck on day 7 of admission
        - If labs remain normal on day 7 of admission, routine labs are not necessary unless clinically indicated
        - If labs remain abnormal, continue checking at least daily until normalized
    - Additional labs may be drawn at the discretion of the accepting treatment facility
- The major manifestations of refeeding syndrome include delirium, chest pain, and heart failure that are associated with hypophosphatemia and depletion of potassium and Mg
- Consider checking post-prandial glucose in patients with "brain fog" or low-normal fasting glucose, especially during the first week of hospitalization
    - Post-prandial hypoglycemia is common in patients with ED and may be asymptomatic or present with atypical symptoms, such as isolated "brain fog" without associated shakiness or sweating
    - Patients on bolus feeds or eating meals, especially early in their nutritional rehabilitation, may have post-prandial hypoglycemia despite normal fasting glucose

Medications: (*The following supplements will be started for all patients upon admission)*

- Provide a pediatric multivitamin with iron PO daily
- Provide calcium carbonate 500 mg PO twice daily (BID)
    - Consider three times daily (TID) if not consuming dairy
- Provide vitamin D3 (cholecalciferol) 2000 units daily for 6 – 8 weeks if serum 25-OH vitamin D level is < 30 ng/dL
- Zinc: For all patients, on admission, start 15 mg (age 4 – 8 years), 30 mg (age 9 – 13 years), or 45 mg (adolescents and adults) elemental zinc PO daily

    - As zinc levels can be falsely elevated in patients with malnutrition, continue the patient on zinc for the duration of hospitalization
    - If the zinc level comes back low, zinc may need to be continued after discharge.
- Provide thiamine/vitamin B1 50 mg/day (children under 13 years) or 100 mg/day (13 years and older)

- *Consider the following depending on the clinical scenario:*
    - Iron: If serum ferritin < 12 ng/mL, provide ferrous sulfate 3 – 6 mg of elemental iron/kg/day for children or 325 mg (65 mg elemental iron)/day for adults
    - If MMA > 0.4 mmol/L, provide vitamin B12 (cyanocobalamin) 250 mcg/day for 8 weeks
    - Prophylactic phosphorus-sodium-potassium (PHOS-NaK) 250 mg PO TID should be prescribed if serum phosphorus level is < 3 mg/dL or is trending downward, <u>OR</u> if serum potassium level is < 3.4 mg/dL or trending downward
    - Mg oxide 400 mg BID or TID should be prescribed if the serum Mg level is < 1.5 mg/dL or trending downward
        - Monitor for diarrhea
    - Once the patient is on full enteral feeds, consider polyethylene glycol (MiraLAX®) 17 g PO nightly if no bowel movement for > 3 days

- IV fluids:
  - Fluid requirements will generally be met by an oral/enteral nutrition plan recommended by the RD
  - IV fluids are not routinely recommended, but may be provided at the provider's discretion based on the clinical status of the patient, taking into consideration their hydration status, electrolytes, and cardiac status

<u>*Patient status recommendations*</u>:

- Patients admitted for medical stabilization and nutritional resuscitation for suspected or confirmed ED should be admitted to inpatient status

<u>*Team communication*</u>:

- The inpatient SW is responsible for coordinating a care conference with the multidisciplinary team within 1 – 2 business days of admission
    - The goal of this meeting is to review the patient's diagnosis, provide education to the caregiver(s), set expectations, and review the plan of care
    - The inpatient SW will coordinate referrals to ED treatment facilities for the corresponding level of care
- The inpatient CM is responsible for verifying insurance and mental health benefits, and educating the caregiver(s) about their plan benefits
    - The inpatient CM will secure the authorization for the safe authorized mode of transportation for transfers to an accepting treatment facility
    - Review of discharge home prescriptions, if applicable

- A second care conference should be considered once the transition plan recommendations are available from members of the multidisciplinary team

Discharge:

Discharge criteria:

Discharge to inpatient or residential:

Criteria for transfers to higher levels of care or treatment facilities may differ depending on facility requirements.

- Patients with an NG tube identified for transfer from JHACH to an ED treatment facility will transfer via a safe authorized mode of transportation to the accepting treatment facility
- SW:
    - Coordinate referrals to the appropriate level of care
    - Assist nursing with the necessary information on the interfacility form for transfer
    - Notify caregiver(s) of the accepting ED treatment facility and provide contact information
    - Coordinate with CM to secure the safe authorized mode of transportation for transfers to an accepting treatment facility
- CM:
    - Obtain insurance authorizations for transportation for transfers for the appropriate level of care
    - Coordinate with SW to secure the safe authorized mode of transportation for transfers to an accepting treatment facility
    - Review of discharge home prescriptions, if applicable
- Providers:
    - Update clinical notes to accurately reflect the use of the NG tube and CPO as part of the clinical pathway
    - Document medical stability once clinical criteria for medical stability have been met
- Nursing:
    - Ensure the interfacility transfer form has been completed
    - Review discharge After Visit Summary (AVS)
    - The NG tube remains in place for transfer if most of the nutrition is received via the NG tube

Discharge criteria for discharge to home:

- Medical criteria:
    - Normal serum chemistries for at least 24 hours
    - Medical instability has resolved, at discretion of medical team: HR > 50 bpm while awake, HR > 45 bpm while asleep, no EKG changes, normal temperature (> 36 ˚C (96.8 ˚F)) taken orally (not axillary), BP normal for age and height, resolution of **symptomatic** orthostasis (decrease in SBP no greater than 20 mmHg and increase in HR no more than 20 bpm) measured after 5 minutes supine rest and then again after 3 minutes standing

- If the patient has a recent history of admission in the last 30 days for the same issue, discharge is at the discretion of the provider
    - Requirements for next levels of care (e.g., IOP or PHP programs) may also inform decisions regarding discharge readiness
- SW: Plan of care in place, including appointments made and confirmed with appropriate providers (e.g., Psychology, Nutrition, PCP)
- A handoff from inpatient to outpatient providers is recommended, when feasible, to facilitate continuity of care
- The patient does not have to complete all 3 phases of the feeding plan to be eligible for discharge
    - The patient does not have to be taking all PO feeds to be eligible for discharge

Documentation Reminders:

- It is important to document the underlying psychiatric diagnosis
    - Refer to the Psychology notes for terminology
    - If Psychology has not yet seen the patient, using terms like “suspected,” “probably,” “presumed,” or “likely” is appropriate
- Review the “Background” section above for assistance
    - Anorexia nervosa, restricting type, F50.01
    - Anorexia nervosa, binge eating/purging type, F50.02
    - Bulimia nervosa, F50.2
    - Binge eating disorder, F50.81
    - Avoidant-restrictive food intake disorder (ARFID), F50.82
    - Other specified eating disorder, F50.89
    - Unspecified eating disorder, F50.9
- It is also important to document the patient’s BMI and degree of malnutrition; refer to the RD’s notes for guidance
    - Mild malnutrition, E44.1
    - Moderate malnutrition, E44.0
    - Severe malnutrition, E43.0
- It is important to document any complications of the patient’s ED, such as bradycardia, orthostatic hypotension, orthostatic tachycardia, electrolyte abnormalities (hypokalemia, hypophosphatemia), refeeding syndrome, lanugo, hair loss, amenorrhea, etc.
- It is important to document any mental health comorbidities that could be contributing to the patient’s disordered eating, avoidant behaviors, or oral aversion

Outcome Measures:

- Frequency of collection of labs: BMP, Mg, Phos
- Frequency of below-normal Phos levels
- Frequency of below-normal Phos levels resulting in supplementation
- Frequency of documented diagnosis of refeeding syndrome

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Clinical Pathway Team
Eating Disorder Clinical Pathway
Johns Hopkins All Children's Hospital

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Date Approved by JHACH Clinical Practice Council: ***

Date Available on Webpage: August 20, 2025

Last Revised: 8/14/2025

Disclaimer:

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners, and other healthcare providers in clinical decision-making by describing a range of generally accepted approaches for the diagnosis, management, or prevention of specific diseases or conditions. The ultimate judgment regarding care of a particular patient must be made by the physician, considering the individual circumstances presented by the patient.

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Appendix A: Calculating Ideal Body Weight (IBW) and % IBW

- IBW is the patient's weight if their BMI were at the 50th percentile for age
- The goal is generally for patients with ED to maintain at least 90 – 110% IBW

Steps to Calculate IBW (with example):

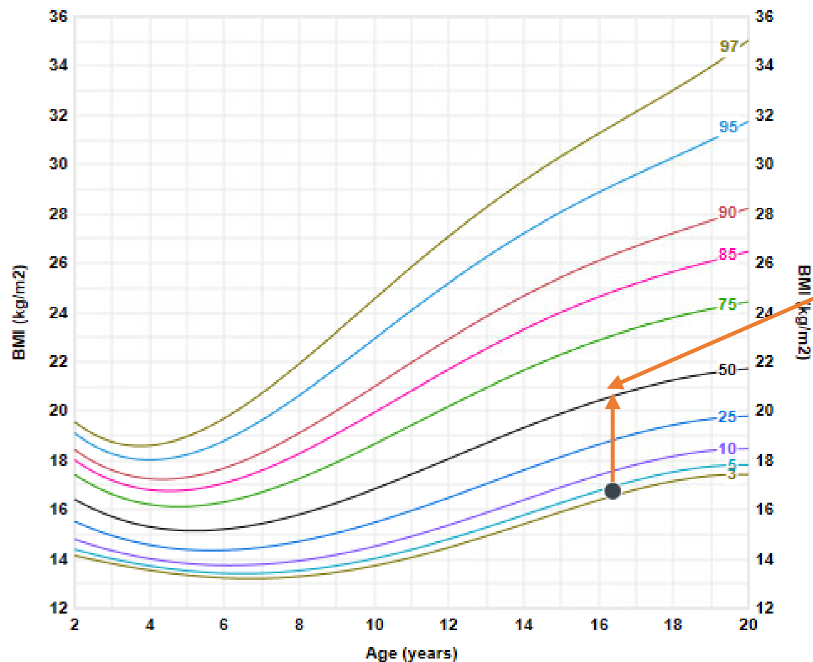
<u>Step 1</u>: Obtain height (m) and weight (kg)

Example: Height: 1.571 m

Weight: 41.3 kg

<u>Step 2</u>: Look at the BMI growth chart (CDC 2 – 20 years) and find what BMI would be at the 50th percentile (can also find BMI at 50th percentile using https://peditools.org/growthpedi/):

Example:



BMI at 50th percentile: 20.6 kg/m^2

<u>Step 3</u>: To find the patient's IBW, use the following equation by entering the BMI from Step 2 and the patient's height to solve for *x* (weight in kg)

$$BMI\ @\ 50th\ percentile = \frac{weight\ (kg)}{height\ (m^2)}$$

$$20.6\ kg/m^2 = \frac{x}{1.571^2}$$

$$x = 50.8\ kg$$

<u>Step 4</u>: Determine the patient's % IBW using the following equation:

$$\%\ IBW = \frac{actual\ weight}{ideal\ weight} \times 100$$

$$81\%\ IBW = \frac{41.3\ kg}{50.8\ kg} \times 100$$

Patient is 81% ideal body weight

Appendix B: Eating Disorder Handout for Caregivers

Goals for this Hospital Stay:

- Your child has been admitted to Johns Hopkins All Children's Hospital (JHACH) under the Eating Disorder Pathway. During this stay, your child will be assessed by many team members, including doctors, psychologists, social workers, and dietitians.
- JHACH is a **medical** facility, not a behavioral health care facility or eating disorder treatment facility. The goal during this stay is to medically stabilize your child so that they are safe to start treatment for their eating disorder after discharge from this hospital.
- We will monitor vital signs, weight, and labs, and provide nutrition based on your child's unique needs. As we do all these things, we will also be working with your child and family to identify the best treatment after discharge and help get you there.

What to Expect in the Hospital:

- You will work closely with a dietitian to address your child's nutrition needs. Medical allergies and religious preferences will be considered.
- Your child's weight and plan of care will be discussed with you, but weights and calories should **not** be discussed or shared in front of your child. These topics are very stressful and triggering to patients with eating disorders. Discussing them could be harmful to your child's safety and recovery.
- A team member will be present to monitor your child throughout this hospital stay. This includes, but is not limited to, during all meals and snacks, bathroom time, shower time, and when leaving the room in a wheelchair.
- Your child may try to restrict or burn calories in ways beyond just limiting food. These can include keeping the room cold to cause shivering, taking cold showers, exercising secretly in the bathroom, shower, or bed, fidgeting, pacing, drinking lots of water, or using laxatives. None of these will be allowed in the hospital.
- It is recommended that your child **not** use electronics. Phones, laptops, gaming devices with internet access, etc., can be and have been used to count calories and learn ways to burn calories without getting caught. Social media can be very toxic to the health of patients with eating disorders. The smart TV in the room can be used for distraction during meals if helpful. If your child is using electronics in a way that is harmful to their progress, the medical team will make a formal recommendation against the use of electronics.
- Eating disorders are often linked to suicidal thoughts or thoughts of self-harm. Concerns about these matters should be addressed openly and honestly.
- Your child's safety and medical stability are our priorities. Please be aware that any statements or behaviors suggesting self-harm or attempts to "runaway" are taken seriously and may involve further restrictions.

Planning for Next Steps:

- The team will organize a care conference within 1 – 2 business days of your arrival. As a group, we will discuss your child's diagnosis and plan of care with you. This meeting typically only includes parents. The topics discussed in the meeting can be triggering for your child.
- It is very important for you to be involved in the planning of your child's future care. Please contact your insurance company after the first care conference to discuss the team's recommendations and make them aware of your child's diagnosis and medical needs. If appropriate, request an insurance case manager from your primary insurance to aid you in this process.
- The next steps after leaving the hospital will depend on your child's unique needs and may include intensive outpatient or even residential treatment for the eating disorder. We will work as a team to figure out the most appropriate and safest route for your child.
- A second, or follow-up, care conference may be held as needed.
- Discharge from the hospital will be considered when a) your child is medically stable and b) a safe plan for their treatment outside of the hospital is in place.

Tips for Caregivers and Supporters:

- Recovery from an eating disorder is a long-term process. There is no quick fix. However, recovery **is** possible, and it is very important to get help as soon as possible.
- Rules and restrictions while your child is in the hospital are not punishments; they are needed for your child's safety.
- Eating disorders are not specific to any race, gender, ethnicity, body type, sexual orientation, or socioeconomic status. They can impact anyone. Do not blame yourself; it is not something you did wrong.
- Remember that a child with an eating disorder is not purposely choosing to do or say harmful or hurtful things. Be positive and try not to take these things personally. The illness, or "eating disorder brain," is affecting the decisions your child makes.
- Be firm and consistent with your child. Avoid power struggles. Do not try to trick, bribe, or force your child to eat.
- Be non-judgmental. Focus on feelings, not weight or food. Obsession with numbers, such as weights and calories, is a dangerous part of eating disorders.
- Many families find it helpful to join support groups for eating disorders. These groups can help you learn about others' experiences with their children's eating disorders and give you a safe space to express yourself and share your own.
- Take care of your own physical, emotional, and spiritual needs. Your child is being kept safe while in the hospital. It is okay to take breaks away from their bedside to meet your personal needs.

Appendix C: Handout for Patients - Expectations for Patients Admitted for Medical Stabilization of Eating Disorder

- An NG tube is placed through your nose to your stomach to safely meet your nutritional needs. This will remain in place from admission to discharge. If your tube comes out during your stay, the nurse will replace it.
- A member of your care team will always be with you. This observation includes but is not limited to bathroom use, shower use, during mealtimes, and when outside the room.
- To ensure your safety, the expectation is to stay in your bed, on your couch, or in a chair while in your room. If there is concern for more frequent movement, your care team will provide reminders.
- Showers will be limited to once daily with warm water only.
- The room thermostat will remain in the 12 o'clock position to maintain a consistent room environment. Please notify your nurse if you suspect your thermostat is malfunctioning.
- Exercise is not allowed during your stay. This includes taking walks, pacing, repetitive movements, etc.
- Gum will not be allowed during your stay.
- For any excursions outside your room, a wheelchair is to be supplied for you to remain in for the entirety of the trip.
- Every morning, after you have urinated, your weight will be measured in a gown and underwear only while you face backwards. Blind weights are used to reduce eating disorder triggers.
- Please don't flush the toilet; your nurse will need to measure the urine and stool after each bathroom use.
- Bathroom use will be allowed 1 hour after completion of meals.
- Once a meal plan is started, meals and snacks will be completed in a chair (not in bed or couch) within a 30-minute timeframe. All napkins must be returned on your tray. In case of concern for hiding food, a gown will be worn during meal and snack times.
- If you are unable to eat and drink all items on your tray (even if only a few bites), the meal or snack's full nutritional value will be offered in the form of oral supplementation. If oral supplementation is declined, nutrition will be provided via your NG tube.
- Your dietitian will work with you and your family to develop a meal plan to meet your nutritional needs. Medically diagnosed allergies and religious exemptions will be considered.
- We prioritize your safety. Any comments made that raise concern for your safety and well-being will be taken seriously.

Page 1 of 1

Appendix D: Task Description for Constant Patient Observer (CPO)

- Obtain start-of-shift report from CPO and bedside RN
    - If no report is available, check in with the Charge RN
- Check NG tube connections for leaks or breaks when vitals are obtained
- Ensure the enteral pump and formula always remain covered
- Blind weights should be taken by 0700
    - Patient must void before weight is taken, and must be in a gown
    - Notify bedside RN or Charge RN if patient does not void, refuses a gown, or refuses weight by 0700
- Eyes and attention must always be on the patient
    - Your view of the patient must be unobstructed
    - You should not have nor be using your phone, should not be using the room computer for personal use, and are not permitted to use headphones
    - Reading a book does not always maintain eyes and attention on the patient
- If you are feeling sleepy or need an immediate break, please call the bedside RN or Charge RN as soon as possible
- Please do not discuss weight, foods, calories, or eating disorder treatment with the patient
- Please notify the bedside RN if you are concerned the patient is using a phone or electronic device inappropriately
    - Examples of concerning behaviors include counting calories, inappropriate social media access, concerning content or videos related to eating, conversations regarding self-harm, elopement (running away), or any other concerning behaviors
    - Patient can have a phone until the medical team places a formal recommendation for no phone/electronic use
    - A caregiver can choose to limit the patient's phone/electronic device use at any time
- During meals:
    - Please check the tray to ensure no items include a nutritional label
        - If identified, do not provide the tray to the patient; notify the bedside RN or Charge RN immediately
    - The patient must be in a stand-alone chair (not in bed or a couch) for the duration of the meal and snacks
        - Caregiver(s) can be present, but will be asked to leave if they are not able to display supportive behaviors during meals
        - TV use is allowed during meals for distraction, unless the patient is watching triggering content
    - Meals and snacks must be consumed within a 30-minute timeframe
        - Patient is expected to consume 100% of the meal and snack, including small bites remaining, condiments ordered on the tray, and all liquids
    - The patient should not have any blankets or outerwear during meals
        - No additional belongings are to be with the patient during meals
        - Napkins must be turned in with the tray and checked
        - Cups and utensils must be confirmed and turned in with the tray

        - Please confirm that clothing is not used to hide food
            - Notify the bedside RN or Charge RN if suspect food is being hidden
    - The patient cannot use the bathroom for 60 minutes following the completion of meals
        - Please report any concerns for purging to the bedside RN or Charge RN as soon as possible
- Patient is not permitted to chew gum
- Patients may utilize the TV
    - Notify the bedside RN or Charge RN if concerning content is viewed
- The patient can leave the room escorted by the CPO
    - Patient must be in a wheelchair for the duration of the excursion
    - Please notify the bedside RN or Charge RN before leaving the unit
    - Excursions may not interfere with meals or snack times
    - The patient is not permitted to visit the cafe or cafeteria
- The temperature in the patient's room is to remain in the midpoint position
    - If there are concerns from the patient or caregiver(s) as to the temperature in the room, notify the bedside RN or Charge RN and Hospitalist team
- Patient is not permitted to exercise throughout admission
    - This includes, but is not limited to, pacing, repetitive or frequent movements around the room, repetitive contracting and relaxing of muscles (i.e., sit-ups, crunches, social media fads, leg lifts, calf raises), and standing activity center activities (i.e., pool, walkway floor activity, stair use)

Appendix E: Printable Handout for Constant Patient Observer (CPO) (2 pages)

<table>
<tr><th>Eating Disorder Constant Patient Observer Checklist</th><th>☑</th></tr>
<tr><td>Obtain the start-of-shift report from the CPO and bedside RN
• If no report available, check in with the Charge RN</td><td>❑</td></tr>
<tr><td>Check NG tube connections for kinks, leaks, or breaks when vitals are obtained</td><td>❑</td></tr>
<tr><td>Ensure the enteral pump and formula always remain covered</td><td>❑</td></tr>
<tr><td>Blind weights should be taken by 0700
• Patient must void before weight is taken, and must be in a gown
• Notify bedside RN or Charge RN if patient does not void, refuses a gown, or refuses weight by 0700</td><td>❑</td></tr>
<tr><td>Measure orthostatics with AM vital signs:
• Have the patient lie down for 5 minutes, take the heart rate and blood pressure
• Have the patient stand for 3 minutes, take another heart rate and blood pressure</td><td>❑</td></tr>
<tr><td colspan="2">During Meals & Snacks:</td></tr>
<tr><td>Please check the tray to ensure no items include a nutritional label
• If identified, do not provide the tray to the patient; notify the bedside RN or Charge RN immediately</td><td>❑</td></tr>
<tr><td>The patient must be in a stand-alone chair (not in bed or a couch) for the duration of the meal and snacks
○ Caregiver(s) can be present, but will be asked to leave if they are not able to display supportive behaviors during meals
○ TV use is allowed during meals for distraction, unless the patient is watching triggering content</td><td>❑</td></tr>
<tr><td>Meals and snacks must be consumed within a 30-minute timeframe
• Patient is expected to consume 100% of the meal and snack, including small bites remaining, condiments ordered on the tray, and all liquids</td><td>❑</td></tr>
<tr><td>The patient should not have any blankets or outerwear during meals
• No additional belongings are to be with the patient during meals
• Napkins must be turned in with the tray and checked
• Cups and utensils must be confirmed and turned in with the tray
• Please confirm that clothing is not used to hide food
○ Notify the bedside RN or Charge RN if suspect food is being hidden</td><td>❑</td></tr>
<tr><td>The patient cannot use the bathroom for 60 minutes following the completion of meals
• Please report any concerns for purging to the bedside RN or Charge RN as soon as possible</td><td>❑</td></tr>
</table>

Please see Page 2 for additional details

CPO Guide

- Eyes and attention must always be on the patient. Your view of the patient must be unobstructed. You should neither have nor use your phone, should not be using the room computer for personal use, and are not permitted to use headphones. Reading a book is also not permitted, as you would not always be maintaining eyes and attention on the patient.

- If you are feeling sleepy or need an immediate break, please call the bedside RN or Charge RN as soon as possible.

- Please do not discuss weight, foods, calories, or eating disorder treatment with the patient. Do not make comments about the food on their tray, serving sizes, or how much they ate.

- Please notify the bedside RN if the patient is counting calories, having inappropriate social media access, having conversations regarding self-harm or elopement (running away), or showing any other concerning behaviors.

- Patient can have their cell phone/electronics unless there are concerns for inappropriate use of the phone/electronics.

- Patient is not permitted to chew gum.

- TV can be utilized by patients, but please notify the bedside RN or Charge RN if concerning content is being viewed

- The patient can leave the room escorted by the CPO. The patient must be in a wheelchair for the duration of the excursion. Please notify the bedside RN or Charge RN before leaving the unit. Excursions may not interfere with meals or snack times
  - Patient is not permitted to visit the cafe or cafeteria.

- The temperature in the patient's room is to remain in the midpoint (12 o'clock) position. If there are concerns from the patient or caregiver(s) about the temperature in the room, notify the bedside RN or Charge RN and Hospitalist team.

- Patient is not permitted to exercise throughout admission. This includes, but is not limited to, pacing, repetitive or frequent movements around the room, repetitive contracting and relaxing of muscles (i.e., sit-ups, crunches, social media fads, leg lifts, calf raises), or standing activity center activities (i.e., pool, walkway floor activity, stair use)

- Please report any additional concerns to the bedside RN or charge RN.

Appendix F: Printable Handouts for Patient and Caregiver(s) (English)

*Please print the **next 3 pages** and distribute them upon admission as follows:*

To patient: "Patient Handout"

To caregiver(s): "Caregiver Handout" AND "Tips for Caregivers"

Patient Handout

Initiation of Eating Disorder Clinical Pathway

Expectations for Patients Admitted for Medical Stabilization of an Eating Disorder

- An NG tube is placed through your nose to your stomach to safely meet your nutritional needs. This will remain in place from admission to discharge. If your tube comes out during your stay, the nurse will replace it.
- A member of your care team will always be with you. This observation includes but is not limited to bathroom use, shower use, during mealtimes, and when outside the room.
- To ensure your safety, the expectation is to stay in your bed, on your couch, or in a chair while in your room. If there is concern for more frequent movement, your care team will supply reminders.
- Showers will be limited to once daily with warm water only.
- The room thermostat will remain in the 12 o'clock position to supply a consistent room environment. Please notify your nurse if you suspect your thermostat is malfunctioning.
- Exercise is not allowed during your stay. This includes taking walks, pacing, repetitive movements, etc.
- Gum will not be allowed during your stay.
- For any excursions outside your room, a wheelchair is to be supplied for you to remain in for the entirety of the trip.
- Every morning, after you have voided, your weight will be measured in a gown and underwear only, facing backwards. Blind weights are used to reduce eating disorder triggers.
- Please don't flush the toilet; your nurse will need to measure the urine and stool after each bathroom use.
- Bathroom use will be allowed 1 hour after completion of meals.
- Once a meal plan is started, meals and snacks will be completed in a chair (not in bed or couch) within a 30-minute timeframe. All napkins must be returned on your tray. In case of concern for hiding food, a gown will be worn during meal and snack times.
- If you are unable to eat and drink all items on your tray (even if only a few bites), the meal or snack's full nutritional value will be offered in the form of oral supplementation. If oral supplementation is declined, nutrition will be provided via your NG tube.
- Your dietitian will work with you and your family to develop a meal plan to meet your nutritional needs. Medically diagnosed allergies and religious exemptions will be considered.
- We prioritize your safety. Any comments made that raise concern for your safety and well-being will be taken seriously.

JOHNS HOPKINS
All Children's Hospital

Caregiver Handout

Initiation of Eating Disorder Clinical Pathway

Goals for This Hospital Stay

Your child has been admitted to Johns Hopkins All Children's Hospital (JHACH) under the Eating Disorder Pathway. During this stay, your child will be assessed by many team members, including doctors, psychologists, social workers, and dietitians.

JHACH is a **medical** facility, not a behavioral health care facility or eating disorder treatment facility. The goal during this stay is to medically stabilize your child so that they are safe to start treatment for their eating disorder after discharge from this hospital.

We will monitor vital signs, weight, and labs, and provide nutrition based on your child's unique needs. As we do all these things, we will also be working with your child and family to identify the best treatment after discharge and help get you there.

What to Expect in the Hospital

- You will work closely with a dietitian to address your child's nutrition needs. Medical allergies and religious preferences will be honored. **-** Your child's weight and plan of care will be discussed with you. Weights and calories should **not** be discussed or shared in front of your child. These topics are very stressful and triggering. Discussing them could be harmful to your child's safety and recovery.

- A team member will be present to monitor your child throughout this hospital stay. This includes (but is not limited to) during all meals and snacks, bathroom time, shower time, and when leaving the room in a wheelchair.

- Your child may try to restrict or burn calories in ways beyond just limiting food. These can include keeping the room cold to cause shivering, taking cold showers, exercising secretly in the bathroom, shower, or bed, fidgeting, pacing, drinking lots of water, and using laxatives. None of these will be allowed in the hospital.

- It is recommended that your child **not** use electronics. Phones, laptops, gaming devices with internet access, etc., can be and have been used to count calories and learn ways to burn calories without getting caught. Social media can be very toxic to the health of patients with eating disorders. The smart TV in the room can be used for distraction during meals if helpful. If your child is using electronics in a way that is harmful to their progress, the medical team will make a formal recommendation against the use of electronics.

- Eating disorders are often linked to suicidal thoughts or thoughts of self-harm. Concerns about these matters should be addressed openly and honestly.

- Your child's safety and medical stability are our priorities. Please be aware that any statements or behaviors suggesting self-harm or attempts to "runaway" are taken seriously and may involve further restrictions.

Planning for Next Steps

- The team will organize a care conference within 1 – 2 business days of your arrival. As a group, we will discuss your child's diagnosis and plan of care with you. This meeting typically only includes parents. The topics discussed in the meeting can be triggering for your child. A second, or follow-up, care conference may be held as needed.

- It is very important for you to be involved in the planning of your child's future care. Please contact your insurance company after the first care conference to discuss the team's recommendations and make them aware of your child's diagnosis and medical needs. If appropriate, request an insurance case manager from your primary insurance to aid you in this process.

- The next steps after leaving the hospital will depend on your child's unique needs and may include intensive outpatient or even residential treatment for the eating disorder. We will work as a team to figure out the most appropriate and safest route for your child.

- Discharge from the hospital will be considered when a) your child is medically stable and b) a safe plan for their treatment outside of the hospital is in place.

JOHNS HOPKINS
All Children's Hospital

- Recovery from an eating disorder is a long-term process. There is no quick fix. However, recovery **is** possible, and it is very important to get help as soon as possible.

- Rules and restrictions while your child is in the hospital are not punishments; they are needed for your child's safety.

- Eating disorders are not specific to any race, gender, ethnicity, body type, sexual orientation, or socioeconomic status. They can impact anyone. No one is to blame; it is not something you did wrong.

- Your child did not choose to have an eating disorder. Remember that a child with an eating disorder is not purposely choosing to do or say harmful or hurtful things. Be positive and try not to take these things personally. The illness, or "eating disorder brain," is affecting the decisions your child makes.

- Be firm and consistent with your child. Avoid power struggles. Do not try to trick, bribe, or force your child to eat.

- Be non-judgmental. Focus on feelings, not weight or food. Obsession with numbers, such as weights and calories, is a dangerous part of eating disorders.

- Many families find it helpful to join support groups for eating disorders. These groups can help you learn about others' experiences with their children's eating disorders and give you a safe space to express yourself and share your own.

- Take care of your own physical, emotional, and spiritual needs. Your child is being kept safe while in the hospital. It is okay to take breaks away from their bedside to meet your personal needs.

Appendix G: Printable Handouts for Patient and Caregiver(s) (SPANISH)

*Please print the **next 3 pages** and distribute them upon admission as follows:*

To patient: “Información para el paciente”

To caregiver(s): “Folleto para el cuidador” AND “Consejos para los cuidadores”

Información para el paciente

Protocolo terapéutico para los trastornos de la conducta alimentaria

A fin de optimizar su recuperación, siga atentamente estas indicaciones si le ingresan en el hospital por trastornos de la conducta alimentaria:

- Se le colocará una sonda nasogástrica para suplir sus necesidades alimentarias adecuadamente, la cual se introducirá por la nariz hasta el estómago. La sonda permanecerá en su lugar desde el ingreso hasta el alta. Si se le sale durante la estadía, la enfermera se la volverá a colocar.
- Un integrante del personal clínico le acompañará en todo momento, incluso cuando use el baño, se duche, coma y cuando salga de la habitación.
- Para garantizar su seguridad, se le pedirá que permanezca en la cama, en el sofá o en una silla mientras esté en la habitación. El personal le indicará si llegara a ser necesario que realice movimientos más frecuentes.
- Solo podrá ducharse una vez al día, con agua tibia únicamente.
- El termostato de la habitación se mantendrá en la misma temperatura durante la estadía, a fin de brindarle un entorno estable. Avise a la enfermera si sospecha que el termostato de la habitación no funciona correctamente.
- No podrá caminar, merodear los pasillos, realizar movimientos repetitivos ni hacer ningún tipo de ejercicio durante su estadía.
- No podrá mascar chicle (goma de mascar) mientras esté en el hospital.
- Cuando tenga que salir de la habitación, se le proporcionará una silla de ruedas, en la que el personal deberá desplazarle.
- Todas las mañanas, una vez que haya orinado o defecado, se le pedirá que se suba a la báscula de espaldas para tomarle el peso. Ni usted verá lo que pesa ni el personal le revelará esta medición, a fin de evitar desencadenantes del trastorno. Deberá vestir una bata y ropa interior únicamente.
- Por favor, no tire de la cadena del inodoro cuando orine o defeque, ya que la enfermera deberá medir la cantidad de orina y heces cada vez que vaya al baño.
- Podrá ir al baño 1 hora después de que termine sus comidas.
- Cuando empiece el régimen de alimentación, deberá consumir las comidas y los refrigerios sentado(a) en una silla (no en la cama ni en el sofá) en un plazo de 30 minutos. Deberá colocar todas las servilletas en la bandeja. Si el personal sospecha que oculta alimentos, le pedirá que se coloque una bata antes de consumir las comidas y las meriendas.
- Debe comer y beber todos los alimentos en la bandeja. Si deja un poquito, se le administrará un complemento por vía oral para suplir el valor nutricional de la porción de comida o de la merienda que no haya consumido. Si se niega a tomarse el complemento por vía oral, la complementación nutricional se le administrará por la sonda nasogástrica.
- Junto con el nutricionista, usted y su familia podrán elaborar un régimen de alimentación que satisfaga sus necesidades nutricionales, teniendo en cuenta las alergias que le hayan diagnosticado y las restricciones alimentarias de índole religiosa.
- Ya que nuestra prioridad es salvaguardar su seguridad, tomaremos en serio cualquier comentario suyo que suponga o implique un perjuicio para su salud o bienestar.

Folleto para el cuidador

Protocolo terapéutico para los trastornos de la conducta alimentaria

Objetivo del ingreso

Los médicos, psicólogos, trabajadores sociales y nutricionistas que conforman el servicio de trastornos de la conducta alimentaria en el Hospital Infantil All Children's de Johns Hopkins evaluarán y atenderán a su hijo(a).

Nuestro hospital es un **centro médico**, no un centro psiquiátrico ni un centro especializado en el tratamiento de los trastornos alimentarios. El objetivo de este ingreso hospitalario es, por tanto, estabilizar al paciente para que, tras el alta, pueda iniciar el tratamiento oportuno del trastorno de manera segura.

Durante la estadía se le medirán las constantes vitales y el peso y se le realizarán los análisis clínicos que correspondan. Antes del alta, asesoraremos al paciente y a su familia para identificar el tratamiento del trastorno que le sea más idóneo y eficaz.

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Medidas que se aplicarán durante la estadía en el hospital:

- El nutricionista asignado le orientará para que juntos aborden las necesidades nutricionales de su hijo(a), teniendo en cuenta las alergias médicas y las restricciones alimentarias de índole religiosa. El personal le explicará el tratamiento y le informará sobre el peso corporal de su hijo(a). Por favor, no hable del peso ni de las calorías delante de él o ella, ya que pueden estresarle y desencadenar las conductas del trastorno, lo que sería perjudicial para su seguridad y recuperación.

- Al paciente se le asignará un profesional quien le supervisará en todo momento durante su estadía, incluso cuando use el baño, se duche, coma y cuando salga de la habitación en la silla de ruedas.

- Además de restringir la ingesta de alimentos, es posible que el paciente intente quemar calorías o evitar consumirlas usando otros medios; p. ej. manteniendo la habitación fría o duchándose con agua fría para producirse escalofríos; haciendo ejercicio en el baño, la ducha o la cama, sin que nadie le vea; moviéndose de manera nerviosa; caminando de un lado al otro; bebiendo mucha agua, y tomando laxantes. Durante su estadía en el hospital no permitiremos que realice estas conductas de evasión.

- El uso de aparatos electrónicos, como celulares, computadoras portátiles, consolas de videojuegos con acceso a internet, etc., **no** está recomendado, ya que pueden habilitar al paciente para que cuente calorías y averigüe métodos para quemarlas sin que lo descubran. Las redes sociales son perjudiciales para la salud de los pacientes que padecen trastornos alimentarios. Si necesitan distraerse, podrán ver la televisión de la habitación mientras comen. Si el personal estima que los aparatos electrónicos son perjudiciales para la recuperación de su hijo(a), se prohibirá su uso.

- Los pacientes con trastornos de la conducta alimentaria suelen tener ideas suicidas o deseos de hacerse daño a sí mismos. Estas inquietudes deben abordarse de manera abierta y honesta.

- Salvaguardar la seguridad y la estabilidad de su hijo(a) es nuestra prioridad, así que tomaremos medidas si se sospecha que quiere hacerse daño o desea escaparse.

Medidas adicionales

- El primer o segundo día hábil tras el ingreso, el personal responsable agendará una reunión con los padres del paciente, a fin de explicarles el diagnóstico y el tratamiento adecuado para su hijo(a). Los temas que se tratan en esta reunión pueden generar ansiedad y desencadenar las conductas del trastorno en el menor, por lo que no debe estar presente. De ser necesario, se agendará una segunda reunión.

- Comuníquese con la compañía de seguros médicos después de la primera reunión con el personal, para que les informe sobre el diagnóstico y las necesidades médicas de su hijo(a) y analicen las repercusiones de esta situación en la cobertura. De ser posible, solicite al seguro la asistencia de un coordinador de casos para que le oriente.

- Los servicios que precise el paciente tras el alta hospitalaria dependerán de sus necesidades concretas, pero podrían abarcar desde tratamientos ambulatorios intensivos hasta el ingreso en un centro especializado en trastornos de la conducta alimentaria. El personal estará a su disposición para orientarle sobre los servicios más adecuados y seguros en el caso de su hijo(a).

- El personal autorizará el alta del hospital cuando el paciente esté estable, desde el punto de vista clínico, y cuando se hayan identificado y coordinado las pautas del tratamiento ambulatorio.

Consejos para los cuidadores

Protocolo terapéutico para los trastornos de la conducta alimentaria

- Recuperarse de un trastorno alimentario puede llevar mucho tiempo, ya que no hay una solución rápida para este tipo de enfermedad. Dicho esto, la recuperación **se** puede lograr, sobre todo si el trastorno se trata cuanto antes.

- Tenga en cuenta que las normas y las restricciones que deben acatar los pacientes en el hospital no son un castigo; por el contrario, se implementan para garantizar su seguridad.

- Los trastornos alimentarios se le pueden presentar a cualquier persona, independientemente de su grupo racial, sexo biológico, etnia, tipo de cuerpo, orientación sexual o nivel socioeconómico, y no son un reflejo de errores ni son culpa de nadie.

- Los trastornos alimentarios no se elijen, simplemente suceden. Si su hijo(a) le ofende o le hiere, recuerde que tiene una enfermedad y que su intención no es hacerle daño. No se ofenda y mantenga una actitud positiva. Esta enfermedad afecta el cerebro y es esta quien, por el momento, controla las decisiones de su hijo(a).

- Sea firme y constante con su hijo(a). No se involucre en peleas o discusiones para ver quién tiene la razón. No intente engañarle, sobornarle ni obligarle para que coma.

- Sea imparcial. Enfóquese en los sentimientos de su hijo(a), no en el peso, en la comida o en las calorías, ya que la obsesión por estos aspectos podría empeorar el trastorno.

- Muchos padres y cuidadores se apuntan a grupos de apoyo sobre trastornos de la conducta alimentaria, ya que así comparten sus propias experiencias y conocen las de otras familias.

- No olvide cuidar de sus propias necesidades físicas, afectivas y espirituales. Su hijo(a) estará a salvo mientras esté en el hospital, así que aproveche para salir y despejarse o para descansar y renovar energías.

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Outpatient Eating Disorder Clinic

To best support you in your continued treatment progress and journey to recovery, we can be considered your long-term eating disorder care team. This clinic is NOT a substitute for an intensive treatment program or weekly therapy, but our team can continue to provide medical care and mental health assessments for ongoing management

This clinic is a unique eating disorder program within the Adolescent and Young Adult Specialty Clinic at Johns Hopkins All Children's Hospital. Your visit with us will include a 2-hour appointment, and you will be evaluated by an adolescent medicine doctor, psychologist/therapist, and dietitian. We will check vital signs, weight, and other body composition measures. We will consider other testing, such as blood work, EKGs, and bone density scans, as needed. Based on your individual needs and the treatment you are currently receiving, we can provide recommendations for potential services to consider. If you encounter a long wait time, please take advantage of Fast Pass access by signing up for MyChart.

Dr. Reese is the Division Chief for Adolescent Medicine and Director of the Eating Disorder Program. During your visit, Dr. Reese will focus on medical diagnosis and medical complications secondary to weight loss, weight changes, and disordered eating behaviors, as well as recommend medical testing and labs as needed.

Dr. Sobalvarro is a pediatric psychologist in the Center for Behavioral Health. Dr. Sobalvarro will focus on assessing emotional health and behaviors of disordered eating. She will provide recommendations for evidence-based interventions to manage disordered eating behaviors and cognitions.

Meg Taylor is a registered clinical nurse for the Adolescent and Young Adult Specialty Clinic. During your visit, Meg will introduce our clinic workflow as well as complete vital signs and medical screening assessments. She will also help with coordinating any labs or testing that you may need.

Rebekah Diaz is a licensed clinical social worker for the Center for Behavioral Health. Rebekah conducts psychosocial assessments as well as provides support and interventions for patients with eating disorders.

Karen Diaz is a registered dietitian who specializes in working with individuals with eating disorders. Karen will help identify challenges that exist with daily meal intake and will help patients and families with meal planning.

A resident, fellow, or provider in training will likely meet with you at each visit under the direction of Dr. Reese and the team. You will also meet with our patient service representatives (PSRs) for scheduling as well as our clinical nursing staff members.

Adolescent and Young Adult Specialty Clinic
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